BY H. ARONSON AND BETTY OVERALL

Treatment Expectations of Patients in Two Social Classes

■ ***This article describes a study of the expectations of middle- and lower-class patients on entering psychotherapy. The results showed that although both groups are aware of the subject matter to be covered, they differ in their expectations of treatment techniques. Similarities as well as differences exist, with various explanations offered to account for them.*** ■

IT IS FAIRLY well established that the prognosis for a successful, completed course of psychotherapy is considerably poorer for lower socioeconomic class patients than for those of higher socioeconomic levels. A large proportion of lower-class patients leave treatment prematurely.[1] Those who continue in psychotherapy are reported to have little interest in or ability to deal with interpersonal concepts and have difficulty in forming a desirable therapeutic relationship.[2] A better understanding of this differential response to therapy by people in different socioeconomic classes would be of both theoretical and practical value. This study attempts to further such understanding by focusing on patient expectancy—a basic determinant of therapeutic behavior.

Patient expectancy (the patient's anticipation of therapy) can be viewed in several ways. The first and most often considered involves the patient's belief in the successful outcome of his treatment. Brady studied expectancy through projective means.[3] The "optimism-pessimism" aspect of expectancy was not found to be helpful in predicting the outcome of treatment. However, the concept may, despite such experimental setbacks, be a useful one, as shown by Friedman and by Goldstein and Shipman.[4] Their results suggest that high hopes may be a bet-

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1 Jerome D. Frank, Lester H. Gliedman, Stanley D. Imber, Earl H. Nash, Jr., and Anthony R. Stone, "Why Patients Leave Psychotherapy," *Archives of Neurology and Psychiatry,* Vol. 77, No. 3 (March 1957), pp. 283–299; and Imber, Nash, and Stone, "Social Class and Duration of Psychotherapy," *Journal of Clinical Psychology,* Vol. 11, No. 3 (July 1955), pp. 281–284.

2 David Rosenthal and Jerome D. Frank, "The Fate of Psychiatric Clinic Outpatients Assigned to Psychotherapy," *Journal of Nervous and Mental Disease,* Vol. 127, No. 4 (October 1958), pp. 330–343.

3 J. P. Brady, Marvin Reznikoff, and W. W. Zeller, "The Relationship of Expectation of Improvement to Actual Improvement of Hospitalized Psychiatric Patients," *Journal of Nervous and Mental Disease,* Vol. 130, No. 1 (January 1960), pp. 41–44.

4 H. J. Friedman, "Patient Expectancy and Symptom Reduction," *Archives of General Psychiatry,* Vol. 8, No. 1 (January 1963), pp. 61–67; and A. P. Goldstein and W. G. Shipman, "Patient Expectancies, Symptom Reduction and Aspects of the Initial Psychotherapeutic Interview," *Journal of Clinical Psychology,* Vol. 17, No. 2 (April 1961), pp. 129–133.

ter predictor of dropout rate or immediate symptom reduction than of final therapeutic success per se.

Another facet of the concept used here is concerned with the patient's initial set or anticipation of the roles, techniques, and events that will occur in therapy. This approach is typified by Apfelbaum, who used a Q-sort analysis and divided the patients' expectations of their prospective therapists into three clusters: nurturant (protective), model (personally well adjusted), and critical (probing).[5] Apfelbaum's patients were seen in a university outpatient facility. It is possible that expectations vary with the agency from which therapy is anticipated and with the complaint for which treatment is sought. Furthermore, patients' responses in such studies are of necessity limited to those offered by the experimenter. This narrowing of scope to a specific population and a finite number of possible sets can also be seen in the present study.

The present discussion of differences in expectancy as a function of social class was derived from the work of Hollingshead and Redlich, which supplies a number of working hypotheses.[6] *The higher a patient's social class, the more he views psychotherapy in psychological rather than medical terms.* That is, lower-class patients see their difficulties as physical in origin and expect medication, support, and direct advice from the therapist. They are unwilling to assume responsibility or have faith in a "talking treatment." The higher socioeconomic class patients are described primarily by omission. Their expectancies are believed to be unlike those of the lower class.

The importance of expectancy in the prediction of dropouts of lower-class patients from psychotherapy was underlined in a previous report by the authors.[7] In that study, a group of patients was seen prior to their initial interviews to obtain their expectations and also immediately following their initial interviews to find their perceptions of the events that had taken place. It was found that patients registering a greater discrepancy between expectation and perception were significantly less likely to return for a second scheduled appointment.

The present study compares the original expectations of the lower-class group in the above study with those of a second group composed of middle-class patients. The hypotheses to be tested, taken directly from the descriptive work of Hollingshead and Redlich, are the following: lower-class patients, in comparison with middle-class patients, will anticipate the therapist to be (1) more medically oriented, (2) more active or directive, and (3) more supportive, and thus will expect the therapist to be (4) less passive and (5) less interested in psychological, i.e., emotional or interpersonal, material.

METHOD

Setting. The psychiatric clinic from which the lower-class patients were obtained is located within a general outpatient building. Patients are referred by other clinics when they are found to require psychiatric treatment. There is no direct opportunity for self-referral.

The middle-class group was studied in an outpatient department located one block from the facility just described. Patients are given appointments only after personal inquiry, usually by phone. Although impetus for contact may come from such varied sources as the family physician or local social agencies, a large proportion of applicants are self-referred.

Subjects. Both lower- and middle-class subjects were patients who came to their respective facilities for their first psychia-

[5] Bernard Apfelbaum, *Dimensions of Transference in Psychotherapy* (Berkeley: University of California Press, 1958).

[6] August B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness* (New York: John Wiley & Sons, 1958).

[7] Betty Overall and H. Aronson, "Expectations of Psychotherapy in Patients of Lower Socioeconomic Class," *American Journal of Orthopsychiatry*, Vol. 33, No. 3 (April 1963), pp. 421–430.

tric visit. Patients who were obviously too disoriented or disturbed to be tested were excluded from the study. With this exception, all patients who met the socioeconomic requirements during the experimental period were accepted for study.

Patients were included in the middle-class group if the head of the house was a high school graduate or a white-collar worker. Less than one-fourth of those who applied for treatment in the middle-class setting failed to meet these criteria. After forty middle-class patients had been interviewed, their social standing was computed on the Hollingshead Two-Factor Index.[8] Since the highest score (lowest social position) obtained was 44, 45 was arbitrarily set as the cut-off point between middle and lower class for the purpose of this study. Only one lower-class patient obtained a score of 44.[9] That patient was dropped from the lower-class group, bringing its number down to 39.

The range of the lower-class group's scores places them in the two lowest positions in the Hollingshead system of social class levels. The authors' definition of middle class includes a rather wide range of steps in the social pyramid. It extends into the group often considered lower-upper class.

Table 1 presents a composite of descriptive data on the two groups. The lower-class group was found to be significantly more variable in age and significantly older than the middle-class group. It contained significantly more Negroes, fewer Jews and had significantly more members born in the southeastern region of the United States and fewer born in Maryland or elsewhere. There were significant differences between the two groups in income, occupation, and education of the head of the house but not in terms of sex or marital status.

Procedure. On his first visit to the clinic and prior to his interview with the therapist each patient was seen by one of the

TABLE 1. A COMPARISON OF LOWER- AND MIDDLE-CLASS PATIENT VARIABLES

Parameter	Lower class (N=39)	Middle class (N=40)
Age		
Range	16–66	19–56
Mean [a]	40.6	33.0
σ [a]	13.3	9.6
Sex		
Male	13	15
Female	26	25
Race [a]		
Caucasian	12	37
Negro	27	3
Religion [a]		
Non-Jewish	38	32
Jewish	0	8
Unknown	1	0
Marital Status		
Married or common-law	16	23
Other	23	17
Birthplace [a]		
Maryland	15	24
Other southeastern states	22	5
Other	2	11
Earned Income, Household [a]		
None to $40.00 per week	25	2
$41.00 and above per week	13	37
Unknown	1	1
Education, Head of House [a]		
Below high school	33	3
High school and above	6	37
Occupation, Head of House [a]		
Blue collar or unemployed	37	0
White collar	2	40
Hollingshead Two-Factor Score		
Range	48–77	15–44
Mean [a]	68.1	35.3
σ	8.0	10.2

[a] Significant differences between classes were found by means of one of the following statistical measures: Mann-Whitney U-test as described in Sidney Siegel, *Nonparametric Statistics for the Behavioral Sciences* (New York: McGraw-Hill Book Co., 1956), F-test, χ^2 test, Fisher's exact probability test, *t*-test.

[8] August B. Hollingshead, *Two-Factor Index of Social Position* (New Haven, Conn.: published by the author, 1957). The Two-Factor Index quantifies social status by assigning weighted scores to the occupation and education of the head of the household. The range of possible scores is 11 through 77, with the lower scores indicating higher social position.

[9] Overall and Aronson, *op. cit.*, p. 423.

experimenters. He was asked to co-operate in a routine hospital study so that the hospital might "better understand and help the patients who come for treatment." The patient was then given an oral questionnaire constructed to measure his expectations of the forthcoming interview.

The questionnaire consisted of thirty-five descriptions of a therapist's possible behavior in an initial interview. The patient was instructed to state, by a "yes" or "no" answer, whether he believed his therapist would proceed in the manner described. Each question was devised to represent one of five aspects and an affirmative response would indicate the presence of that aspect. The five categories are not mutually exclusive; however, each question was considered as representing a single aspect. The categories were:

1. Medical. Therapist focuses on the organic or physical problems of the patient. *Do you think the doctor will be interested in your digestion?*

2. Directive. Therapist actively instructs or directs patient. *Do you think the doctor will tell you what is causing your trouble?*

3. Supportive. Therapist avoids charged material in an attempt to bolster or comfort the patient. *Do you think the doctor will try to get your mind off your troubles?*

4. Passive. Therapist leaves the direction of the discussion to the patient, encouraging all patient communication. *Do you think the doctor will expect you to do most of the talking?*

5. Psychological. Therapist focuses on emotional or dynamic material. *Do you think the doctor will want to know how you get along with people?*

RESULTS

Class differences. Table 2 gives examples of the questions asked and the percentage of affirmative responses made by the two groups. The responses to twenty-seven of the thirty-five questions correspond to the

TABLE 2. QUESTIONNAIRE ITEMS THAT OBTAINED SIGNIFICANT DIFFERENCES BETWEEN CLASSES

Category number [a]	Do you think the doctor will . . .?	Lower class [b] (percent)	Middle class [b] (percent)
Medical (11 items in all)			
1.	give you medicine.	56	18
18.	be interested in your digestion	72	42
24.	be particularly interested in your aches and pains.	67	40
32.	take your pulse and blood pressure.	54	25
34.	tell you what kinds of food you should eat.	46	10
Directive (12 items in all)			
3.	tell you what is wrong with you.	59	22
7.	give you definite rules to follow.	67	28
12.	tell you what is causing your trouble.	62	20
20.	tell you ways to solve your problems.	74	28
21.	have a list of things he will want to check over.	67	35
28.	tell you what is wrong with what you do.	69	32
Supportive (4 items in all)			
4.	try and cheer you up.	77	48
8.	avoid subjects which might upset you.	53	15
14.	want you to look at the bright side of things.	87	65
25.	try to get your mind off your troubles.	79	35
Passive (3 items in all)			
6.	listen more than he talks.	77	100
23.	expect you to do most of the talking.	67	92
Psychological (9 items in all)			
29.	not give you a physical examination.	51	78

[a] Only those items which reached a significant difference are listed here. The complete questionnaire can be found in Betty Overall and H. Aronson, "Expectations of Psychotherapy in Patients of Lower Socioeconomic Class," *American Journal of Orthopsychiatry*, Vol. 33, No. 3 (April 1963), pp. 421–430. Significance was determined by χ^2 and Fisher's exact probability test. The number preceding each question indicates its position within the questionnaire.

[b] Lower class N=38 for Items 8 and 14, 39 for all others. Middle class N=40.

hypothesis. Of these, eighteen show a significant difference between the two classes. Of the items in which the results fall contrary to the hypotheses, none approaches significance.

The largest proportion of significant differences fall in three of the five categories: directive, supportive, and passive. Of the fifteen items in these categories, twelve fall in the direction hypothesized. All twelve items are significant and a majority of them show a highly significant difference between the groups. The lower-class patient generally expects more action, direction, and support from the therapist than the middle-class patient.

While the above categories strongly support the hypotheses, the findings on medical items show a considerably less sharp or definitive difference; only five of the eleven items reach significance here. It would appear that although both groups anticipate some focus on somatic aspects, the middle-class group expects somewhat less specificity or concern with physical matters by the therapist. That is, although both lower- and middle-class patients expect to be questioned to some extent on medical *history,* it is mainly the lower class who anticipate an examination of or specific interest in *current* physical problems.

The psychological category shows the least difference between social classes. Only one of the nine items placed in this category shows significance and that item, on physical examination, might have been considered medical. In general, since so high a percentage of "yes" responses was made by the lower-class patients, there was little opportunity for the middle-class group to demonstrate a difference in psychological expectations. These results show only that items suggested by the literature are not fruitful. If a difference is present, it is not as extreme as hypothesized.

Other pertinent variables. As noted in Table 1, there are significant differences between the two groups in terms of age, race, religion, and place of birth. It is possible that the differences in treatment expectations arose, not on the basis of social class, but on the basis of these other variables. The data were re-examined for evidence of such influence.

Place of birth appears to correlate highly with race. Age and class also correlate, with lower-class patients tending to be older. The focus of examination was, therefore, centered on the variables race and religion.

Race and religion correspond to socio-economic class; the Negroes were predominantly in the lower-class group and the Jews totally in the middle-class group. However, here it was possible to examine differences within the groups—lower-class Negroes vs. lower-class whites, middle-class Jews vs. middle-class non-Jews. In comparison with the lower-class whites, the lower-class Negroes tended to respond more in the direction hypothesized for the lower class. That is, the Negro group differed most strongly from the middle-class whites. The lower-class whites, for all the significant questions, fall between the two and are generally nearer the Negro than the middle-class whites. Since the Negro patients represented the lower end of the lower-class group, these results are consistent with a class as well as a racial interpretation.

One question does appear to be more properly attributed to race than social class. "Avoid subjects which might upset you" was answered "yes" by 17 percent of the lower-class white group, 16 percent of the middle-class white group, and 67 percent of the lower-class Negro group. Here it would appear that the significant difference may be due to the racial composition rather than a class difference between the groups.

When the percent of "yes" responses is compared for the three groups middle-class Jews, middle-class non-Jews, and lower-class whites, the Jews are often furthest from the lower-class whites, with the middle-class non-Jews falling between. This

cannot be explained only in terms of class difference since the Jews of this study cluster around the lower end of the middle-class group.

The most striking aspect of the Jewish results was their practice of saying "no." In comparison with middle-class non-Jews, the percent of "yes" responses of the Jews is lower for thirty-two, equal for one, and higher for only two of the thirty-five questions. This may be due to an attitudinal difference toward therapy within the Jewish group or may merely reflect a general response set of "when in doubt, say 'no.'" While, since there were only eight Jewish patients, a negative attitude on the part of one patient could easily have distorted the percentages, this does raise an interesting question for further study.

DISCUSSION

One immediate conclusion that can be drawn from the above results is that although there are obvious differences between the lower and middle classes in their expectations of psychotherapeutic techniques, there are also rather broad similarities. While there were a number of items on which the two groups differed by more than 30 percent, there was not a single item for which the difference was greater than 50 percent. Thus, knowledge of social class in and of itself is not sufficient to allow for exact predictions on an individual basis.

It would appear that both classes expect the therapist to show some interest in their physical well-being. Many patients would be surprised if some note of their medical histories was not made at an early point. The middle class, however, does not appear to expect as detailed or specific an examination as the lower class and, perhaps even more important, does not as often expect physical treatment of its disorders. This finding is in agreement with the descriptive work of Hollingshead and Redlich and is reasonable in light of the fact that the lower-class patient's principal complaint is commonly of a somatic nature.

The results here are unlike those suggested by Hollingshead and Redlich in that the majority of both middle- and lower-class patients did expect their initial interviewer to focus on aspects of their psychological experiences. This lack of differentiation between classes could easily be the result of poor test items. More important, however, the high percentage of responses by both groups shows that at least some degree of sophistication and understanding of psychological dynamics is present in both classes.

In general, the greatest discrepancy between the classes results from a difference in anticipating the therapeutic techniques to be utilized, not from a divergence of opinion concerning the content of therapy. The middle class, more than the lower class, recognizes that much of the initiation and direction in a dynamic interview must come from the patient. It is also more aware that the solution of difficulties is not likely to come in the form of a "papal edict."

This major class difference can be due to any of several reasons: (1) The discrepancy in social status between a patient and his therapist is greater for the lower-class patient. This may cause him to undervalue his judgment and feel that the therapist is in possession of a greater knowledge. (2) The lower-class patient simply may be less able to say "no," regardless of the question asked him. (3) Perhaps the middle-class patient is better informed, either by friends or by a more prudent use of the mass media. (4) The lower-class patient may have based his judgment on past experiences with medical personnel or, more important, with authority figures in general. In fact, an over-all difference in cultural experience may have led the lower-class patient to behave typically in a more dependent manner. The specific nature of this differential expectation would deter-

mine the therapeutic countermeasures to be chosen.

The greater the unacknowledged difference between patient and therapist in expectation and evaluation of the techniques to be utilized, the more likely the patient will be to doubt the therapist's ability and to have a general increase in nontherapeutic anxiety. If such a reaction is a common result of a discrepancy in expectancy between therapist and patient, it may partially explain the observable phenomenon of less frequent dropouts of higher-class patients. This would follow from the fact that upper-class expectations of the therapist's behavior correspond more closely to the methods used in the majority of private offices and clinics today.

The lower class, much more than the middle class, expects the therapist to have either as a therapeutic technique, a goal, or perhaps both, the amelioration of discomforting thoughts. For many this would mean that the therapist would be expected to make frequent reassurances and, in general, to "tread lightly" for fear of making the patient anxious. With the lower-class Negro, the therapist is expected to go so far as to join the patient in suppressing—to "avoid subjects which might upset" him. The middle-class patient, on the conscious level, is more likely to recognize that disturbing subjects and their concomitant painful affects are readily aroused by therapy. When this inevitably happens in interpretive therapy, the middle-class patient is not as likely to feel that therapy is doing him a disservice.

If the difference between classes is due merely to a difference in the fund of knowledge, it would be a relatively simple matter to begin the lower-class patient's therapy with a period of cognitive re-education. However, there are numerous indications that the difference is a matter of upbringing, attitudes, and way of living and may be basic to the character structure of the mature adult.[10]

Theory appears to place direct reduction of anxiety and uncovering ("depth" therapy) as polar opposites. Supportive therapy is more often considered appropriate for the lower class and psychological probing for the middle class. However, the lower-class patient appears to anticipate psychological probing and may be able to deal with it if anxiety is held within the range with which he can cope. Perhaps it may be possible to use uncovering techniques while taking measures to maintain a supportive atmosphere. Certainly the therapist should keep in mind that anxiety may be interpreted differently by patients of differing social levels.

SUMMARY

Two patient populations, representing the middle and lower socioeconomic classes, were compared for their expectation of psychotherapy. This was determined by means of a questionnaire given to each patient before his first psychiatric interview. It focused on the categories of a therapist's possible behavior suggested by Hollingshead and Redlich—medical or psychological orientation and active, supportive, or passive quality of activity—as being differentially anticipated by the social classes.

It was found that, while both groups expected the therapist to focus on psychological interests, the middle class expected less emphasis on physical matters. The lower class more often expected the therapist to be supportive, direct, and active than did the middle class. These findings were interpreted as showing a difference in expectation of technique but not necessarily in the content matter of therapy.

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10 Allison Davis and R. J. Havighurst, "Social Class and Color Differences in Child Rearing," *American Sociological Review*, Vol. 11, No. 6 (December 1946), pp. 698–710; and Alfred C. Kinsey, W. B. Pomeroy, and C. E. Martin, *Sexual Behavior in the Human Male* (Philadelphia: W. B. Saunders Co., 1948).